104TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 104–87
Part 1

MEDICARE PARTS B AND C ADMINISTRATION BUDGET SAVINGS EXTENSION ACT OF 1995

MARCH 23, 1995.—Ordered to be printed

Mr. BLILEY, from the Committee on Commerce, submitted the following

REPORT

together with

MINORITY VIEWS

[To accompany H.R. 1217]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred the bill (H.R. 1217) to amend parts B and C of title XVIII of the Social Security Act to extend certain savings provisions under the medicare program, as incorporated in the budget submitted by the President for fiscal year 1996, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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99–006

PURPOSE AND SUMMARY

The purpose of H.R. 1217, the Medicare Parts B and C Administration Budget Savings Extension Act of 1995, is to extend specific savings provisions under the Medicare Program, as proposed in the budget submitted by the President for Fiscal Year 1996. These policies concern the beneficiary premium under the Part B program, payments to home health agencies, and the Medicare Secondary Payer Program.

BACKGROUND AND NEED FOR LEGISLATION

BACKGROUND ON THE MEDICARE PROGRAM

Medicare is a Federal health insurance program for the aged and certain disabled individuals. It consists of two parts: the hospital insurance (Part A) program and the supplementary medical insurance (Part B) program. Most Americans age 65 or older are automatically entitled to protection under Part A. Also eligible, after a 2-year waiting period, are people under age 65 who are receiving monthly Social Security benefits on the basis of disability and disabled railroad retirement system annuitants. Most people who need a kidney transplant or renal dialysis are, under certain circumstances, entitled to Part A benefits regardless of age as part of the End Stage Renal Disease (ESRD) Program.

Medicare is an entitlement program. After Social Security, it is the second largest social welfare program in the Federal Budget. The Medicare Program closely resembles a traditional insurance program with deductibles and coinsurance requirements, limits on payments to providers, and coverage for a limited set of services.

A few key facts about the Program overall:

In FY 1995, the program will cover approximately 35.7 million people.

In FY 1995, total Medicare outlays are estimated at $181.1 billion.

Between 1980 and 1994, spending has increased at an annual rate of 11.4% and Medicare's share of the total Federal budget has increased from 5.4% to 9.7%.

CBO has recently estimated that Medicare outlays will increase at an average annual rate of 10.0% between 1995 and 2000.

Part A, the Hospital Insurance Program, is financed primarily through a payroll tax levied on current workers and their employers which is deposited into the Medicare Hospital Insurance (HI) Trust Fund. Currently, employers and employees each pay a tax of 1.45% on all earnings.

Medicare Part A provides coverage for hospital services, up to 100 days of post-hospital skilled nursing facilities benefits, home health services, and hospice care. Patients must pay a deductible of $716 in FY 1995. Medicare makes payments for inpatient hospital services under a prospective payment system (PPS): a predetermined rate is paid for each hospital stay based on the patient's admitting diagnosis.

Part B

Part B, the Supplementary Medical Insurance Program, is financed through general revenues and beneficiary premiums. The current beneficiary premium is $46.10 per month. Beneficiary premiums represent about 25% of Part B costs; when Medicare was enacted, premiums represented 50% of program costs.

Part B provides coverage for physicians' services, laboratory services, durable medical equipment, outpatient hospital services, and other medical services. The Program generally pays 80% of Medicare's fee schedule after the beneficiary has met the annual $100 deductible. The beneficiary is liable for the remaining 20% of the fee schedule payment.

Payment for physicians' services is made on the basis of a fee schedule. Specific payment rules are also used for other services. Physicians may bill up to 15% above the fee schedule amount.

Participation in Part B is voluntary; all persons age 65 or older may elect to enroll in the program by paying the monthly premium.

The Medicare Program offers a choice of traditional fee-for-service or managed care plans. Ninety one percent of Medicare beneficiaries are enrolled in fee-for-service plans in 1995, in which enrollees can obtain services from any provider. Nine percent of Medicare enrollees are in managed care plans in 1995 (up from 7% in 1993). Most of these managed care plans pay capitated rates, offer additional benefits, such as prescription drugs, and do not pay for patients to go outside the network except in emergency or exceptional situations.

NEED FOR LEGISLATION

The President's Fiscal Year 1995 Budget Proposal recommends enactment of legislation to extend and modify certain policies in current law. If these proposals are not enacted, Medicare spending will increase.

H.R. 1217 implements these recommendations by providing for:

(1) Permanent extension of the requirement that the Part B premium be set at 25% of Part B program costs.

A Part B premium is paid by or on behalf of all Medicare beneficiaries. Under current law, the Part B premium is set to cover 25% of program costs. The monthly Part B premium that was assumed to cover 25% of program costs is set in statute as follows: $29.90 in 1991, $31.80 in 1992, $36.60 in 1993, $41.10 in 1994, and $46.10 in 1995. The premium is estimated to be $43.70 in 1996 and $48.20 in 1997. Without an extension, this provision will expire after 1998 and the method for calculating the premium will revert to a formula in which the Part B premium increase is limited to the percentage by which cash benefits are increased under the Social Security Program's cost-of-living adjustment (COLA). The COLA adjustment will not keep up with growth in the Part B program. The Administration estimates that without an extension of current law, the percentage of program costs covered by the premium will decline to less than 25% by the year 2000 and to 15.7% in the year 2005.

(2) Extension of the savings from the Omnibus Reconciliation Act of 1993 (OBRA 93) temporary two year freeze on home health agencies.

Medicare reimburses home health agencies (HHAs) on a reasonable cost basis, subject to aggregate cost limits which are updated annually. These limits are set at 112% of the mean labor-related and nonlabor-related per visit costs for HHAs. OBRA 1993 placed a two year freeze on the payment limits during the period from July 1, 1994 to June 30, 1996. The limits will be updated on July 1, 1996 and if statutory changes are not made, when the updates are calculated, the increases in costs that occurred during the two year freeze would be taken into account.

H.R. 1217 does not continue the freeze; rather it provides that in calculating future updates to the per visit for home health agencies, the Secretary must adjust the relevant data to disregard increases in costs that would have occurred during the period from July 1, 1994 to June 30, 1996 if the freeze had not been in place. Absent this provision, home health providers could effectively "catch up" and the savings from these OBRA 1993 provisions would be lost in future years.

(3) Extension of the OBRA 93 provisions concerning Medicare Secondary Payer.

Generally, Medicare is the first payer of health claims with a beneficiary's private or other public insurance filling in some or all of the program's coverage gaps. However, under certain circumstances, if a Medicare beneficiary has insurance coverage in addition to Medicare, that insurance is required to pay claims before Medicare pays. The Medicare Secondary Payer Program is intended to help the Medicare Program identify situations where another health care plan should be, or should have been, the primary payer for a beneficiary's health services. Medicare has special rules which make it a secondary payer for beneficiaries who have group health plan coverage through their current employment or the current employment of a spouse under certain circumstances. Medicare becomes the secondary payer if the beneficiary receives coverage: under a large employer group based health plan in the case of a disabled beneficiary; or under a group health plan of more than 20 employees in the case of a beneficiary over the age of 65. Furthermore, a group health plan cannot deny coverage to a Medicare ESRD beneficiary during the first 18 months of the beneficiary's entitlement to Medicare. In these cases, the beneficiary's private insurance is expected to pay first and Medicare is the secondary payer.

H.R. 1217 extends several provisions permanently that would otherwise expire in 1998:

(1) HCFA is required to contact employers whose health plans cover Medicare beneficiaries to determine health coverage information. If Medicare determines that it paid claims for a Medicare beneficiary or spouse who had private insurance that should have paid first, then Medicare seeks appropriate reimbursement from the private insurer.

(2) Medicare is the secondary payer for disabled individuals with employer-based health insurance offered by employers of 100 or more employees.

(3) When a person is entitled to Medicare on the basis of end stage renal disease (ESRD), current law requires non-Medicare insurers to be the primary payor for ESRD patients for the first 18 months of Medicare entitlement.

HEARINGS

The Subcommittee on Health and the Environment held an oversight hearing on the President's Fiscal Year 1996 Budget proposals for the Medicare Program on March 14, 1995. Ms. Kathleen Buto, Associate Administrator for Policy at the Health Care Financing Administration, testified on behalf of the Administration.

COMMITTEE CONSIDERATION

On March 15, 1995, the Full Committee, met in open markup session and by unanimous consent proceeded to the immediate consideration of H.R. 1217, the Medicare Parts B and C Administration Budget Savings Extension Act of 1995.

The Committee ordered H.R. 1217 reported to the House, without amendment, by a recorded vote of 23 ayes to 19 nays, a quorum being present.

ROLLCALL VOTES

Pursuant to clause 2(l)(2)(B) of rule XI of the Rules of the House of Representatives, following are listed the recorded votes on the motion to report H.R. 1217 and on amendments offered to the measure, including the names of those Members voting for and against.

COMMITTEE ON COMMERCE—104TH CONGRESS ROLLCALL VOTE NO. 34

Bill: H.R. 1217, Medicare Parts B and C Administration Budget Savings Extension Act.

Amendment: Amendment by Ms. Eshoo and Mr. Brown re: direct all savings from the enactment of Medicare extenders to deficit reduction.

Disposition: Not agreed to, by a rollcall vote of 18 ayes to 23 nays.

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bliley		X		Mr. Dingell	X		
Mr. Moorhead		X		Mr. Waxman	X		
Mr. Fields		X		Mr. Markey	X		
Mr. Oxley		X		Mr. Tauzin			
Mr. Bilirakis		X		Mr. Wyden	X		
Mr. Schaefer		X		Mr. Hall	X		
Mr. Barton		X		Mr. Byrant			
Mr. Hastert		X		Mr. Boucher	X		
Mr. Upton		X		Mr. Manton	X		
Mr. Stearns		X		Mr. Towns	X		
Mr. Paxon				Mr. Studds	X		
Mr. Gillmor		X		Mr. Pallone		X	
Mr. Klug		X		Mr. Brown	X		
Mr. Franks		X		Mrs. Lincoln	X		
Mr. Greenwood		X		Mr. Gordon	X		

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Crapo		X		Ms. Furse	X		
Mr. Cox		X		Mr. Deutsch	X		
Mr. Burr		X		Mr. Rush	X		
Mr. Bilbray		X		Ms. Eshoo	X		
Mr. Whitfield		X		Mr. Klink	X		
Mr. Ganske		X		Mr. Stupak	X		
Mr. Frisa							
Mr. Norwood		X					
Mr. White							
Mr. Coburn		X					

COMMITTEE ON COMMERCE—104TH CONGRESS ROLLCALL VOTE NO. 35

Bill: H.R. 1217, Medicare Parts B and C Administration Budget Savings Extension Act.

Motion: Motion by Mr. Bilirakis to order H.R. 1217 reported to the House.

Disposition: Agreed to, by a rollcall vote of 23 ayes and 19 nays.

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bliley	X			Mr. Dingell		X	
Mr. Moorhead	X			Mr. Waxman		X	
Mr. Fields	X			Mr. Markey		X	
Mr. Oxley	X			Mr. Tauzin			
Mr. Bilirakis	X			Mr. Wyden		X	
Mr. Schaefer	X			Mr. Hall		X	
Mr. Barton	X			Mr. Byrant			
Mr. Hastert	X			Mr. Boucher		X	
Mr. Upton	X			Mr. Manton		X	
Mr. Stearns	X			Mr. Towns		X	
Mr. Paxon				Mr. Studds		X	
Mr. Gillmor	X			Mr. Pallone		X	
Mr. Klug	X			Mr. Brown		X	
Mr. Franks	X			Mrs. Lincoln		X	
Mr. Greenwood	X			Mr. Gordon		X	
Mr. Crapo	X			Ms. Furse		X	
Mr. Cox	X			Mr. Deutsch		X	
Mr. Burr	X			Mr. Rush		X	
Mr. Bilbray	X			Ms. Eshoo		X	
Mr. Whitfield	X			Mr. Klink		X	
Mr. Ganske	X			Mr. Stupak		X	
Mr. Frisa							
Mr. Norwood	X						
Mr. Frisa	X						
Mr. White	X						
Mr. Coburn	X						

COMMITTEE ON OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Subcommittee on Health and Environment held an oversight hearing and made findings that are reflected in this report.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that enactment of H.R. 1217 would result in no additional cost to the Federal Government.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, following is the cost estimate provided by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 20, 1995.

Hon. THOMAS J. BLILEY, JR.,
Chairman, Committee on Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1217, as ordered reported by the House Committee on Commerce on March 15, 1995. Enactment of H.R. 1217 would affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 1217.

2. Bill Title: Medicare Parts B and C Administration Budget Savings Extension Act of 1995.

3. Bill status: As ordered reported by the House Committee on Commerce on March 15, 1995.

4. Bill purpose: To amend parts B and C of title XVIII of the Social Security Act to extend certain savings provisions under the medicare program, as incorporated in the budget submitted by the President for fiscal year 1996.

5. Estimated cost to the Federal Government: The bill would affect Medicare benefits, Medicare premiums, and Medicaid. The following table shows projected outlays for these programs under current law, the changes that would stem from the bill, and the projected outlays for each program if the bill were enacted.

[Outlays by fiscal year, in million of dollars]

	1995	1996	1997	1998	1999	2000
Projected spending under current law:						
Medicare mandatory outlays[1]	178,155	199,066	219,411	240,412	263,397	288,095
Medicare premium receipts	−20,090	−20,321	−21,956	−24,494	−26,057	−27,337
Federal Medicaid outlays	89,216	99,292	110,021	122,060	134,830	148,116
Total	247,281	278,037	307,475	337,977	372,170	408,874

[Outlays by fiscal year, in million of dollars]

	1995	1996	1997	1998	1999	2000
Proposed changes:						
Medicare mandatory outlays[1]	0	−10	−299	−457	−1,765	−1,964
Medicare premium receipts	0	0	0	0	−1,325	−3,883
Federal Medicaid outlays	0	0	0	0	106	310
Total	0	−10	−299	−457	−2,984	−5,537
Projected spending under H.R. 1217:						
Medicare mandatory outlays[1]	178,155	199,056	219,111	239,955	261,632	286,131
Medicare premium receipts	−20,090	−20,321	−21,956	−24,494	−27,382	−31,220
Federal Medicaid outlays	89,216	99,292	110,021	122,060	134,936	148,426
Total	247,281	278,027	307,176	337,521	369,186	403,337

[1] Primarily payments for benefits.

The costs of this bill fall within budget functions 550 and 570.

6. Basis of Estimate: Three provisions of the bill would have a significant budgetary impact. Their effects are described below and itemized in the table at the end of this section.

Extension of 25 Percent SMI Premium.—Section 101 would permanently extend the 25 percent Supplementary Medical Insurance premium. Under current law, the premium is set to cover 25 percent of the costs of the aged population in calendar years 1996 through 1998; in 1999 and beyond, the SMI premium will increase by the amount of the Social Security cost-of-living adjustment (COLA). Basing the premium on program costs, which are projected to grow much more rapidly than the COLA, will increase receipts from premiums in 1999 and 2000. Extending the 25-percent SMI premium increases costs to the Medicaid program, which pays the premium increases costs to the Medicaid program, which pays the premium for the approximately 15 percent of the Medicare population with low income.

Medicare Secondary Payer.—Section 201 would permanently extend certain Medicare Secondary Payer (MSP) provisions from OBRA–93. Under current law, MSP for the disabled, MSP for End State Renal Disease (ESRD) patients, and the MSP data match would expire in 1998. These provisions make Medicare the secondary payer for disabled beneficiaries and those with ESRD. The date match provision authorizes a link between Medicare, Social Security, and the Internal Revenue Service to obtain information about cases where another payer exists.

Home Health Cost Limits.—Section 202 would maintain the savings from the provision in OBRA–93 that froze the cost limits for Medicare payments to home health agencies (HHAs). Medicare's payments to HHAs are based on the agency's cost, subject to specified limits. Usually, the cost limits are computed each years so that they reflect the average growth in costs among home health providers. A provision in OBRA–93, however, froze the limits for two years ending on July 1, 1996. H.R. 1217 would maintain the savings from the freeze by ignoring cost growth during those two years when setting cost limits for future years.

[Outlays by fiscal year, in millions of dollars]

	1996	1997	1998	1999	2000
Extension of 25% SMI premium:					
Medicare premium receipts	0	0	0	−1,325	−3,883
Medicaid offset	0	0	0	106	310
Medicare secondary payer	0	0	0	−1,250	−1,400
Home health cost limits	−10	−299	−457	−515	−564
Total	−10	−299	−457	−2,984	−5,537

7. Pay-as-you-go considerations: Section 252 of the Balanced Budget and Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. The pay-as-you-go effects of the bill are as follows:

[By fiscal year, in millions of dollars]

	1995	1996	1997	1998
Outlays	0	−10	−299	−457
Receipts	[1]	[1]	[1]	[1]

[1] Not applicable.

8. Estimated cost to State and local governments: The Medicaid program is financed jointly by the federal and state governments. The extension of the 25 percent SMI premium would require state and local governments to spend an additional $80 million in 1999 and $234 million in 2000 to help pay the premiums of low-income beneficiaries.

9. Estimate Comparison: None.

10. Previous CBO Estimate: CBO estimates that the budgetary impact of H.R. 1217 is equal to the impact of the three corresponding provisions in H.R. 1134, which was ordered reported by the Committee on Ways and Means on March 8, 1995. The estimated total costs of H.R. 1217 and H.R. 1134 differ because H.R. 1134 also included a provision affecting cost limits for skilled nursing facilities.

11. Estimated prepared by: Scott Harrison and Lori Housman.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of Rule XI of the House of Representatives, the Committee finds that the bill would have no inflationary impact.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

SECTION 1. SHORT TITLE

Section 1 provides the short title of the bill: the Medicare Parts B and C Administration Budget Savings Extension Act of 1995.

TITLE I—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

Section 101. Setting the part B premium at 25 percent of program expenditures permanently

Section 101(a) provides that the Part B premium be set at 25% of estimated program cost for aged Medicare beneficiaries.

Section 101(b) makes conforming changes.

TITLE II—PROVISIONS RELATING TO PARTS A AND B OF THE MEDICARE PROGRAM

Section 210. Permanent extension of certain secondary payer provisions

Section 201

(a) Data Match.—This provision makes permanent the requirement that the Health Care Financing Administration must contact employers whose health plans cover Medicare beneficiaries to determine health coverage information. If Medicare determines that it paid claims for a Medicare beneficiary or spouse who had private insurance that should have paid first, then Medicare seeks appropriate reimbursement from the private insurer.

(b) Application to Disabled Individuals in Large Group Health Plans.—This provision makes permanent the provision in current law that specifies that Medicare is the secondary payer for disabled individuals with employer-based health insurance offered by employers of 100 or more employees.

(c) Period of Application of Individual with End Stage Renal Disease.—This provision makes permanent the provision in current law that provides when a person is entitled to Medicare on the basis of end stage renal disease (ESRD), non-Medicare insurers are required to be the primary payer for ESRD patients for the first 18 months.

Section 202. Maintaining savings, resulting from temporary freeze on payment increases for home health services.

Section 202

(a) Basing Updates to Per Visit Cost Limits on Limits for Fiscal Year 1993.—This provision provides that, in calculating future updates to the per visit limits for home health agencies, the Secretary must adjust the relevant data to disregard increases in costs that would have occurred during the period from July 1, 1994 to June 30, 1996 if the freeze had not been in place.

(b) No Exceptions Permitted Based on Amendment.—This provision provides that the Secretary may not consider the modification to current law made in Subsection 9a) when determining exemptions and exceptions to the aggregate cost limitations.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted

is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

ENROLLMENT PERIODS

SEC. 1837. (a) * * *

* * * * * * *

(i)(1) In the case of an individual who—

(A) at the time the individual first satisfies paragraph (1) or (2) of section 1836, is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment status, and

(B) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1836, is enrolled in a large group health plan (as that term is defined in section [1862(b)(1)(B)(iv)] *1862(b)(1)(B)(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual) and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).

(2) In the case of an individual who—

(A) * * *

* * * * * * *

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan (as that term is defined in section [1862(b)(1)(B)(iv)] *1862(b)(1)(B)(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual) and has not terminated enrollment under this section at any time at

which the individual is not enrolled in such a large group health plan by reason of the individual's current employment status (or the current employment status of a family member of the individual) there shall be a special enrollment period described in paragraph (3)(B).

(3)(A) * * *

(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a large group health plan (as that term is defined in section [1862(b)(1)(B)(iv)] *1862(b)(1)(B)(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual) ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

* * * * * * *÷

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) * * *

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall, except as provided in subsections [(b) and (e)], *(b), (c), (e), and (f),* be the amount determined under paragraph (3).

(3) The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar years. [The monthly premium shall (except as otherwise provided in subsection (e)) be equal to the smaller of—

[(A) the monthly actuarial rate for enrollees age 65 and over, determine according to paragraph (1) of this subsection, for that calendar year, or

[(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of $900, that applied to individuals who become eligible for and entitled to old-age insurance benefits on November 1 of the year before the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals for the following November 1.] *The monthly premium shall be equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined according to paragraph (1), for that succeeding calendar year.*

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1)

[and the derivation of the dollar amounts specified in this paragraph].

* * * * * * *

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (a) or (e) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individuals spouse's) current employment status or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan that term is defined in section [1862(b)(1)(B)(iv)] *1862(b)(1)(B)(iii)* by reason of the individual's current employment status (or the current employment status of a family member of the individual). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

(e)[(1)(A) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after December 1995 and prior to January 1999 shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

[(B)] Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month in—

[(i)] *(1)* 1991 shall be $29.90,

[(ii)] *(2)* shall be $31.80,

[(iii)] *(3)* 1993 shall be $36.60,

[(iv)] *(4)* 1994 shall be $41.10, and

[(v)] *(5)* 1995 shall be $46.10.

[(2) Any increases in premium amounts taking effect prior to January 1998 by reason of paragraph (1) shall be taken into account for purposes of determining increases thereafter under subsection (a)(3).]

* * * * * * *

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

(v)(1)(A) * * *

* * * * * * *

(L)(i) * * *

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(iii) Not later than July 1, 1991, and annually thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996), the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886(d)(3)(E) and determined using the survey of the most recent available wages and wage-related costs of hospitals located in the geographic area in which the home health agency is located (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1886(d)(8)(B), a decision of the Medicare Geographic Classification Review Board under section 1886(d)(10), or a decision of the Secretary). *In establishing limits under this subparagraph, the Secretary may not take into account any changes in the costs of the provision of services furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.*

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EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) * * *

(b) MEDICARE AS SECONDARY PAYER.—

(1) REQUIREMENTS OF GROUP HEALTH PLANS.—

(A) * * *

(B) DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(i) IN GENERAL.—A large group health plan (as defined in clause [(iv)] *(iii)*) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this title under section 226(b).

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[(iii) SUNSET.—Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before October 1, 1998.

[(iv)] *(iii)* LARGE GROUP HEALTH PLAN DEFINED.—In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2)

of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this title under section 226A during the [12-month] *18-month* period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this title when an individual is entitled to or eligible for benefits under this title under section 226A after the end of the [12-month] *18-month* period described in clause (i). [Effective for items and services furnished on or after February 1, 1991, and before October 1, 1998 (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears.]

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(5) IDENTIFICATION OF SECONDARY PAYER SITUATIONS.—

(A) * * *

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(C) CONTACTING EMPLOYERS.—

(i) * * *

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[(iii) SUNSET ON REQUIREMENT.—Clause (ii) shall not apply to inquiries made after September 30, 1998.]

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MINORITY VIEWS

We object to the favorable reporting of this bill for a number of reasons.

The legislation was considered through a highly irregular and poorly defined process. It involves substantial cuts in the Medicare program and thus merits appropriate and proper consideration in a regular process. Although the individual provisions of the bill are essentially extensions of current law policies, a cavalier treatment which ignores the potential impacts in costs and on access to quality care for senior citizens in never appropriate. Such provisions should be considered in the context of a budget reconciliation bill or a health reform bill where proper treatment can be given to these issues.

Supporters of the bill specifically refused to identify the purposes for which savings would be used or to dedicate the money for any particular purpose. This abandons the Committee's traditional commitment to making such changes in full recognition and understanding of the entire range of possible approaches to budget savings. Historically, this has been accomplished in the context of budget reconciliation.

In the absence of a comprehensive reform bill, the only appropriate place to put the savings generated by this legislation would be back into the Medicare program or toward deficit reduction. Republicans on the Committee specifically rejected an amendment that would have earmarked these savings for deficit reduction. And the bill itself does not seek specifically to shore up the Medicare program. Indeed, at the markup, the author of the bill explicitly acknowledged a lack of control over where the savings would be used.

Consideration in a vacuum of a few isolated changes in the Medicare program makes little sense when major programmatic changes are promised and will likely be proposed in a few weeks or months as part of the regular budget process. In the absence of such a process, cohesive budgetary and Medicare policies become impossible.

The refusal to deal explicitly with the use of the savings suggests that the processing of the legislation was part of a public relations gimmick—aimed perhaps at funding a tax cut. If this was the aim of the legislation, then this should have been made explicit. Many members have concerns about financing tax cuts—particularly those that favor wealthier Americans at the expense of the middle class—with new burdens on elderly Americans.

In sum, Democrats support deficit reduction, meaningful health care reform, and stabilization and improvement of the Medicare program. Where changes in the program can be undertaken to achieve these ends, we intent to be fully supportive. However, where changes are used for unspecified or political ends, we cannot support them—no matter how non-controversial they are made out to be. Placing new burdens on Medicare beneficiaries, providers

and private employers should never be taken lightly. And they never should be made part of a larger political game.

For these reasons we respectfully dissent from the views expressed by the majority.

JOHN D. DINGELL.
HENRY A. WAXMAN.
EDWARD J. MARKEY.
W.J. BILLY TAUZIN.
RON WYDEN.
RALPH M. HALL.
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BART GORDON.
ELIZABETH FURSE.
PETER DEUTSCH.
BOBBY L. RUSH.
ANNA G. ESHOO.
RON KLINK.
BART STUPAK.

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